Account Set-Up Form

Please Type

PRACTICE / FACILITY INFORMATION:

Ship to Entity Name: _____ Org NPI#: _____

Ship to Address: _____

City: _____ State: _____ Zip: _____

Administrator First Name: _____ Last Name: _____

Email: _____ Phone #: _____

Specialty: (Internist, etc.) _____ Moderate CLIA #: _____

Resale Certificate #: _____ Affiliate Location to Account #: _____

Always Ship via our Carrier ☐ FedEx ☐ UPS ☐ USPS Account# _____

CONSULTANT INFORMATION:

Consultant Name: Michael S. Chavez ID#: 14066

BANKING INFORMATION: *(Payment required prior to shipping Zelle & Wire payments also available)*

ACH INFORMATION: (takes 6 banking days to fund)

ACCOUNT NAME: _____ ACCOUNT PHONE: _____

ROUTING #: _____ ACCOUNT #: _____

CREDIT CARD INFORMATION:

TYPE OF CARD (Check one): ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DEBIT CARD ☐ PROCARD

NAME ON CARD: _____

CARD #: _____ EXPIRATION: _____/_____ SECURITY CODE: _____

BILLING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

I hereby authorize the supplier to charge our debit/credit card listed above for items which were ordered by one of our authorized representatives. I agree that in order to ship items, payment in full must be received prior to shipping. This authorization shall remain in effect until the Service Provider and bank receive written notification from me of intent to terminate at such time and in such manner as to afford the Service Provider and bank reasonable opportunity to act (Minimum 30 days). I understand that all sales are final and there are no refunds or returns since these medical items. I indemnify and hold the Service Provider, the bank, and Merchant harmless from damage, loss or claim resulting from all authorized actions.

AUTHORIZED SIGNATURE: X_____ DATE: _____

PLEASE SEND COMPLETED FORM TO: Enrollment@VantageRx.com

Admin Only: Account ID# _____ Rev. 082020